

STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR



Report on Over-Bedding
and
Formal Recommendations

Mildred Mitchell Bateman Hospital

and

William R. Sharpe Jr. Hospital

August 22, 2011

INTRODUCTION

On July 19, 2011 a hearing was conducted before The Honorable Judge Louis “Duke” Bloom in the matter of *E.H., et al, v. Khan Matin, et al*, to review two issues; the delay in implementation of the Traumatic Brain Injury Waiver and the persistent overpopulation of the two state psychiatric facilities, Mildred Mitchell Bateman Hospital, hereinafter referred to as “Bateman Hospital” and William R. Sharpe Jr. Hospital, hereinafter referred to as “Sharpe Hospital”.

The hearing resulted in an order by the court, dated August 18, 2011. The Court recognized that over-crowding of the state psychiatric facilities continues to violate state law, regulations, and the Orders entered in this case. The Court instructed the Court Monitor to continue to oversee and address compliance with state law and regulations in the hospitals and monitor the Department of Health and Human Resources (DHHR’s) progress and compliance with the Court’s Orders.

In order to monitor DHHR’s compliance with state law and regulations pertaining to over-crowding of its psychiatric facilities, and to review conditions at both Bateman and Sharpe Hospitals, including the impact of those conditions on treatment and civil rights of patients, the Court Monitor scheduled on-site visits at both facilities in August of 2011.

Contained within this report are the observations and findings made during the monitoring visit. Formal Recommendations will be proposed at the conclusion.

BATEMAN HOSPITAL

The Court Monitor scheduled an on-site visit of Bateman Hospital on August 1st and 3rd of 2011. During his review and investigation the Court Monitor conducted (34) interviews; 16 with patients and 18 with staff. The interviews included a cross section of professional disciplines (health service workers, nurses, mid-level management, psychiatrists, social workers and psychologists). The patient interviews were also from a cross section of individuals with varying lengths of stays. All disability groups were represented, including some forensic patients (those hospitalized by the Court as being Not Guilty by Reason of Mental Illness or not competent to stand trial for legal offenses).

FINDINGS

- The staff morale across all employees appeared to be significantly improved from a previous on-site visit in 2008.
- The patient units appeared to be significantly more organized and less chaotic and all patients in the hospital at the time of the visit had access to a private bathroom.

■ It was reported that it remains difficult to recruit psychiatrists. The entry level salaries being offered are not competitive with the community market. It should be reported that at the time of the visit, 6 physicians were on staff and there were two additional vacancies.

■ While Bateman Hospital has been able to operate within its licensed capacity over the past two years, there has been an increase in admissions during May and June of 2011. This has once again caused a problem in the hospital's ability to operate within its licensed capacity. Professional staff reports that the increase in admissions seems to be attributable to two factors: an increase in the number of individuals with addictions being hospitalized, and an increase in the severity of illness of those with mental health challenges, thereby requiring a longer average length of stay.

■ All psychiatrists interviewed expressed the need for improved entry level salaries as well as the need for more community-based placement alternatives. One psychiatrist indicated that he had 9 patients on his caseload who are ready for discharge but no appropriate placement is available in the community. It should be understood that most of these patients will require 24 hour supervision at the time of their discharge. Many have significant medical issues and several have a history of sexual offenses. A focus needs to be placed on specialty options for group homes.

■ Some staff interviewed believes that it is important to hire a permanent chief administrator (CEO) at the hospital. The Interim CEO has been acting in that capacity for approximately 18 months.

■ Hiring and retaining staff was mentioned as being problematic at all levels throughout the hospital, although there are currently no vacancies for Health Service Workers at Bateman.

■ At the time of the visit there were 28 forensic patients at the hospital. The hospital currently has a licensed capacity of 110. On August 1, 2011, the census was four over licensed capacity (114) and on August 3, 2011 the census was under licensed capacity by one (109).

■ Mixing the populations of forensic, addicted, intellectually disabled, newly admitted and long term patients remains problematic on the units, according to some staff interviewed. This Office has mentioned the problematic nature of this policy on several occasions.

■ Some staff voiced concerns about personnel issues within the hospital. Since this was not one of the issues monitored by the Court, staff was directed to the Grievance process already in place. Some staff expressed the belief that the grievance process was ineffective within the hospital.

■ Some staff interviewed believes that attitudes and morale have changed for the better at the hospital because of changes in leadership at the hospital and in Charleston.

■ There appear to be some problems in the relationships between medical staff and some other departments of the hospital. This has no direct relationship to the overpopulation concerns, and is offered solely for the attention of a new CEO once employed.

■ Overall, staff morale at Bateman Hospital has improved remarkably since the Monitor's 2008 visit and report. Management should be proud of the efforts of all employees who have been a part of the many changes that have taken place at this hospital. There remains a problem in staff recruitment and retention in many positions within this hospital, however it is believed that this is common across the medical community in the Huntington, West Virginia, job market.

SHARPE HOSPITAL

The Court Monitor visited Sharpe Hospital on August 9th, 10th and 11th, 2011. During the review and investigation the Court Monitor conducted (45) interviews; 19 with patients and 26 with staff. The interviews represented a cross section of professional disciplines including health service workers, nurses, mid-level management, psychologists and social workers. The patient interviews were also from a cross section of the patient population with varying lengths of stays and disability groups, including forensic patients.

FINDINGS

■ Sharpe Hospital has a licensed capacity of 150 patients. The census at the time of the review was 149 patients on August 9th, 150 patients on August 10th, and 151 patients on August 11th. This census is significantly lower than the average population over the past two years. The hospital had been running an average daily census of approximately 15 to 17 patients over its licensed capacity over the last two years, in spite of the diversion of forensic patients to other facilities, including Bateman.

- Individuals interviewed indicated that staff shortages in the admissions department made it difficult to handle diversions to private psychiatric facilities from Sharpe effectively.
- Some persons interviewed indicated that salaries for registered and licensed practical nurses are not competitive with the local job market.
- Most staff interviewed was concerned about the mixing of the patient populations on almost all of the Units. As an example, on August 9th, Unit G-2 had a patient mix of forensic, intellectually disabled, longer term, acute, and addicted individuals and one patient with dementia. Professional and other staff expressed a concern that this mixture was potentially volatile and hazardous to staff and patients. In the opinion of the Court Monitor, no effective treatment regimen could be implemented other than medication administration.
- Some staff interviewed described the hospital as operating in a “survival mode rather than a treatment mode”.
- Nurses and health service workers reported that the blood pressure machines on all units were not operational. This was observed to be the case. Obviously, this is unacceptable in a hospital setting where reading vital signs is crucial to providing adequate medical monitoring for patients with physical conditions.

- Staff and patients expressed concern that when the hospital is over its licensed capacity, patients are moved into rooms never intended for patient occupancy. As a result, privacy is compromised and patients do not have access to a personal bathroom. Storage for private belongings is also limited in these rooms. This is in direct violation of regulations contained in 64 CSR 59, Behavioral Health Client Rights.
- Some staff suggested that representatives of the Comprehensive Community Behavioral Health Centers are not adequately assisting with discharges from the hospital.
- Staff continues to express the belief that they do not receive appropriate training to work with the forensic patient at the hospital.
- Health Service Workers (HSW) continue to complain that the mandatory over-time policy currently in place is not fair and “very tough” for some of these staff and their families. Sharpe Hospital does have unfilled vacancies for HSWs. The policy was recently reviewed and updated by management.
- Five patients who work on a lawn crew at the hospital informed the Monitor that they had not received their paychecks for work recently completed. Upon further review and investigation with the CEO, it was confirmed these patients were unfortunately caught in an administrative “glitch” and as a result their paychecks were approximately two weeks

behind schedule. The administrator has remedied this issue since the Monitor's visit.

■ On a positive note, all of the Unit telephones checked by the Monitor were functional at the time of his visit.

CONCLUSION

The overall environment, staff morale, treatment quality, and physical conditions are worse than they were in 2010 when the Monitor's last report, "A Review of Over-bedding at William R. Sharpe Jr. Hospital and Formal Recommendations" was completed. It is the opinion of the Court Monitor that the overpopulation of this facility contributes significantly to the current low staff morale that was observed across all professional disciplines. A defeatist attitude currently exists at this hospital. Many staff is retiring and some are seeking employment elsewhere in order to avoid the hospital's working environment. Treatment quality and effectiveness cannot help but be compromised in this environment.

FORMAL RECOMMENDATIONS

BATEMAN HOSPITAL

Formal Recommendation #1. The Department of Health and Human Resources (DHHR) shall cease the practice of admitting patients at Bateman Hospital once the hospital has reached its licensed capacity. It is recommended that when the hospital is beyond its licensed capacity of 110 patients, the Court shall impose a one thousand dollar (\$1,000.00) per day sanction against DHHR. Financial revenue accrued in this “sanction account” shall be disbursed to a newly developed patient/staff account on a regular basis by the parties and the Court Monitor. Parameters will be developed by the parties and the Court Monitor for the disbursement of these funds. These sanction fees will be levied 45 days from the date of this report.

Formal Recommendation #2. DHHR and Bateman Hospital shall develop a plan which prevents inappropriate mixture of clinical populations by November 1, 2011. The plan will describe timelines for implementation of a unit distribution plan which will prevent the

assignment of clinically varied population groups to the same unit. Forensic patients should not be mixed with acute care populations. Individuals with intellectual disabilities should be treated in separate structured units in which behavior management and community integration activities can be provided by appropriately trained staff. Individuals with substance abuse disorders should continue to receive treatment in the self-contained specialty unit that was recently developed at this hospital.

Formal Recommendation #3. DHHR shall employ a permanent Chief Executive Officer (CEO) for this hospital within sixty days (60) from the date of this report.

FORMAL RECOMMENDATIONS

SHARPE HOSPITAL

Formal Recommendation #1. The Department of Health and Human Resources (DHHR) shall cease the practice of over-bedding at Sharpe Hospital. . It is recommended that when the hospital is beyond its licensed capacity of 150 patients, the Court shall impose a one thousand dollar (\$1,000.00) per day sanction against DHHR. Financial revenue accrued in this “sanction account” shall be disbursed to a newly developed

patient/staff account on a regular basis by the parties and the Court Monitor. Parameters will be developed by the parties and the Court Monitor for the disbursement of these funds. These sanction fees will be levied 45 days from the date of this report.

Formal Recommendation #2. DHHR and Sharpe Hospital shall develop a plan which prevents inappropriate mixture of clinical populations by November 1, 2011. The plan will describe timelines for implementation of a unit distribution plan which will prevent the assignment of clinically varied population groups to the same unit. Forensic patients should not be mixed with acute care populations. Individuals with intellectual disabilities should be treated in separate structured units in which behavior management and community integration activities can be provided by appropriately trained staff. Individuals with substance abuse disorders should receive treatment in a self-contained specialty unit similar to the program that was recently developed at Bateman Hospital.

Formal Recommendation #3. DHHR and Sharpe Hospital shall reimburse those patients who are employed by the hospital in a timely matter. Payroll checks to patients shall be made on time. Because patients are to be treated in the state psychiatric hospital system only if dangerous to themselves and others, the Monitor suggests that the clinical teams

review the placement options for patients serving on the lawn mowing teams. It seems counter-intuitive that one can be mentally ill to the point that one is dangerous to self or others and yet be paid to mow lawns.

Formal Recommendation #4. DHHR and Sharpe Hospital shall purchase at a minimum six (6) new blood pressure machines, one for each unit at the hospital and shall establish a safety officer or team whose function is to monitor the operability of hospital and patient equipment and the condition of the hospital environment with regard to health and safety issues for patients and staff. The Safety program shall document reviews of equipment and environmental functionality and maintenance quarterly.

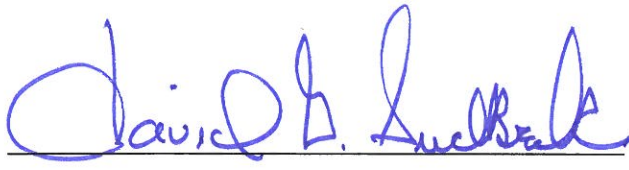
SUMMARY

The Court Monitor would like to thank the 79 patients and staff who were interviewed for this report at Bateman and Sharpe Hospitals. In addition, the Court Monitor would like to thank the advocates from Legal Aid Society of Charleston for their assistance throughout this review/investigation.

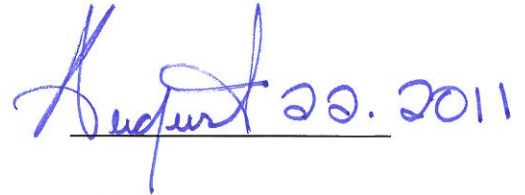
Input provided by clinical staff during the review indicates to the Court Monitor that treatment is being compromised when over-bedding occurs at Sharpe Hospital. Environmental conditions that exist as a result of over-bedding are also interfering with the staff's ability to address basic care needs of the patients at Sharpe Hospital.

Staff at Bateman Hospital should be commended for their efforts to make improvements over the past three years. The treatment milieu and quality are seemingly greatly improved at Bateman Hospital

Pursuant to Section 8.02(6)(c) of the West Virginia Behavioral Health Care Delivery System Plan, the Parties may file objections to the Court Monitor's Formal Recommendations within fifteen (15) business days of the date below.

A handwritten signature in blue ink, reading "David G. Sudbeck", written over a horizontal line.

David G. Sudbeck, Court Monitor

A handwritten date in blue ink, reading "August 22, 2011", written over a horizontal line.

August 22, 2011

CC: The Honorable Judge Bloom
Jennifer Wagner, Esq.
Wendy Elswick, Esq.

